



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

DEPARTMENT OF VETERANS AFFAIRS

Independent Review of VA's
Special Disabilities Capacity
Reports for Fiscal Years 2017
and 2018

REVIEW

REPORT #19-06382-111

APRIL 16, 2020



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DEPARTMENT OF VETERANS AFFAIRS
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WASHINGTON, DC 20001



MEMORANDUM

TO: VA Under Secretary for Health

FROM: Assistant Inspector General for Audits and Evaluations (52)
VA Office of Inspector General

SUBJECT: Independent Review of VA's Special Disabilities Capacity Reports for Fiscal Years 2017 and 2018

VA Office of Inspector General's Independent Review of the Accuracy of VA's Capacity Reports

VA is required to submit an annual report to Congress documenting the agency's capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans in five areas: (1) spinal cord injury and disorder, (2) traumatic brain injury, (3) blind rehabilitation, (4) prosthetics and sensory aids, and (5) mental health. Each year the VA Office of Inspector General (OIG) is required, in turn, to report to Congress on the accuracy of VA's special disabilities capacity reports.¹ Because VA's fiscal year (FY) 2017 and FY 2018 reports were issued to Congress less than a year apart, the OIG reviewed both reports in one product.²

Background

Title 38 of the United States Code, Section 1706 (38 U.S.C. § 1706), requires VA to maintain its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans at a level not below that which was available as of October 9, 1996.³ VA management is responsible for the information presented in its FY 2017 and FY 2018 Special Disabilities Capacity Reports (capacity reports). See Appendix D of the full report that follows for VA's management representation letters.

¹ 38 U.S.C. § 1706(b)(5). The OIG is required to submit to Congress a certification as to the accuracy of VA's capacity reports. The VA and OIG reporting requirements have expired and been reinstated several times since 2004.

² The FY 2017 report was not issued until November 2018, seven months after the April 1, 2018, due date, while the FY 2018 report was issued in March of 2019.

³ 38 U.S.C. § 1706(b).

Scope and Methodology

The OIG conducted the review according to attestation standards established by the American Institute of Certified Public Accountants and by the applicable generally accepted government auditing standards. According to the American Institute of Certified Public Accountants, an attestation review is substantially narrower in scope than an examination, with the latter expressing an opinion. The OIG does not express an opinion. The purpose of this review is to provide a limited degree of assurance as to whether the subject matter is presented in all material respects accurately and fairly, and to express a conclusion, as required by attestation review standards. Also as required by attestation review standards, the inquiries and analytic procedures the OIG performed were designed to provide limited assurances that the required information in the capacity reports is accurate, and to identify material errors. Appendix A to the full report provides additional detail on the review team's analytic procedures.

Issue 1: VA's Capacity Reports Contained Material Errors, Inaccuracies, Inconsistencies, and Material Changes in Capacity

The OIG concluded that the FY 2017 and FY 2018 capacity reports contained material errors, inaccuracies, inconsistencies, and material changes in capacity from FY 2017 to FY 2018.⁴ For example, at a long-term care center the review team visited, the count of operational beds was 30, compared to the 34 that VA reported in its capacity reports (nearly a 12 percent difference). The center provided the team with documentation from November 2014 requesting an adjustment in the official count to 30, due to physical space limitations, but officials from the Spinal Cord Injuries and Disorders System of Care said they did not recall communication about this request.

Issue 2: Limitations in Data Sources and Reporting Reduced the Accuracy of Capacity Reports

The review team discovered inherent data limitations in some of the data sources used for the capacity reports. For example, administrative data are generally reported at the point of service, can be reported differently by different medical facilities, and are prone to data entry and coding errors. The accuracy of the reports was also affected by VA's inability to report data that would allow comparisons to its 1996 capacity. VA reported it cannot do so because of how veterans with diagnoses in the five special disability areas are diagnosed and treated, how services are

⁴ VA, Capacity to Provide Services to Veterans with Disabilities of Spinal Cord Dysfunction, Amputations, Blindness, and Mental Health – 2017, November 2018; VA, Capacity to Provide Services to Veterans with Disabilities of Spinal Cord Dysfunction, Amputations, Blindness, and Mental Health – 2018, March 2019. The review team defined a material change from FY 2017 to FY 2018 as an increase or decrease equal to or greater than 10 percent and a material error as one resulting in a difference of equal to or greater than 10 percent between a reported value and an actual value (if a reported value was found to be inaccurate).

provided, and how data are collected currently, as compared to 1996. Finally, VA also did not accurately report its current capacity because it did not report all required data for services nationally, for veterans integrated service networks, and for medical facilities. As a result, VA's current capacity cannot be compared to capacity from 1996, the data are not necessarily comparable across facilities, and data errors may be difficult to identify. See the full report for more details.

Conclusion

With the exception of the effects of the material errors, inaccuracies, inconsistencies, material changes in capacity from FY 2017 to FY 2018, and data limitations discussed as issues in this memorandum and detailed in the report, nothing came to the review team's attention that caused the OIG to believe that the information required by 38 U.S.C. § 1706 in the FY 2017 and FY 2018 capacity reports is not fairly stated and accurate in all material respects. That conclusion is based on attestation standards used for this review. The OIG believes that VA is no longer able to fully meet the requirement to compare to 1996 capacity because of changes since 1996 to medical diagnoses, treatments, treatment settings, infrastructure, information technology, data systems, and terminology. However, the OIG also believes that Congress is better positioned to assess VA's current capacity to provide care for today's veterans disabled by spinal cord injuries, traumatic brain injuries, blindness, or mental illness, or with the need for prosthetics and sensory aids by requiring VA, for example, to report on its capacity from one year to the next and by considering the extent to which VA can meet the demand for health care and services by veterans affected by these disabilities.

Management Comments

The OIG provided VA with a draft of this report for review and comment. The executive in charge, Office of the Under Secretary for Health, concurred with the contents of the draft report and provided the OIG with general and technical comments which were incorporated into the final report. Specifically, the Veterans Health Administration (VHA) asked OIG to point out that changes in treatment settings, infrastructure, and information technology, in addition to other limitations already discussed by the OIG, have affected VA's ability to compare its current capacity to its 1996 capacity. VHA also provided updated documentation to support additional actions the Spinal Cord Injuries and Disorders System of Care program office took in response to OIG findings to verify bed counts at its care centers. These actions should improve the accuracy of VHA's reporting to meet mandated requirements in future years. The OIG also updated report language related to a lack of clarity around the number of specialized centers for spinal cord injuries and disorders that VHA reported in its capacity reports as compared to data reported in the reports' appendixes. VHA also provided the OIG with management representation letters for both FY 2017 and FY 2018, as required by attestation review standards. See Appendix C of the full report for VHA's comments.

This report is intended to provide information to VA management and Congress. This report is not intended to be used for any other purpose.⁵



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⁵ American Institute of Certified Public Accountants, *Statements of Standards for Attestation Engagements*, AT-C sec. 210, "Review Engagements."

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Abbreviations

FTE	full-time equivalent
FY	fiscal year
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	veterans integrated service network

Introduction

VA is required to maintain its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans at a level not below that available as of October 9, 1996, under Title 38 of the United States Code, Section 1706 (38 U.S.C. § 1706). This requirement was designed to ensure that the decentralization of Veterans Health Administration's (VHA) field management structure in the late 1990s would not adversely impact VA's capacity to serve disabled veterans. The law requires VA to submit an annual report to Congress documenting its compliance and detailing capacity measures for the following five areas:

- Spinal cord injury and disorder
- Traumatic brain injury
- Blind rehabilitation
- Prosthetics and sensory aids
- Mental health

The VA Office of Inspector General (OIG) is required to report to Congress on the accuracy of VA's annual special disabilities capacity reports.⁶

What the OIG Did

To fulfill its legislatively mandated responsibility, the OIG reviewed whether VA accurately reported its in-house capacity to provide for the specialized treatment and rehabilitative needs of specified groups of veterans receiving care or support for disabilities in these five areas. This review also sought to determine whether VA maintained its capacity from fiscal year (FY) 2017 to FY 2018, because the primary purpose of 38 U.S.C. § 1706 is to monitor changes in VA's capacity since October 1996. The OIG conducted the review according to attestation standards established by the American Institute of Certified Public Accountants and by the applicable generally accepted government auditing standards.⁷

⁶ 38 U.S.C. § 1706(b)(5). The OIG is required to submit to Congress a certification as to the accuracy of VA's capacity reports.

⁷ American Institute of Certified Public Accountants, *Statements of Standards for Attestation Engagements*, AT-C sec. 210, "Review Engagements"; Government Accountability Office, *Government Auditing Standards*, GAO-12-331G, December 2011.

VA and OIG Reporting Requirements

The mandate requiring VA to submit an annual capacity report to Congress expired several times—from 2004 to 2005, and again from 2008 to 2016.⁸ In 2016, Congress reinstated the annual capacity reporting requirement for VA for FY 2017 and beyond, as well as the requirement that the OIG certify the accuracy of VA's annual report each year.⁹

Special Disability Areas: Data Sources and Requirements

The OIG met with officials from each of the VA program offices that oversee services for the five special disability areas to learn more about the services provided and data sources for VA's capacity reports. These program offices are the Spinal Cord Injuries and Disorders System of Care, Polytrauma/Traumatic Brain Injury System of Care, Blind Rehabilitation Services, Prosthetic and Sensory Aid Service, and the Northeast Program Evaluation Center. The Northeast Program Evaluation Center is responsible for compiling the mental health data for the capacity reports.

Spinal Cord Injury and Disorder

For spinal cord injury and disorder, services are provided in 24 specialized centers throughout the country. Required data for the capacity report are bed and associated staffing counts, which are reported through a monthly "bed and staffing survey" collected by VA's Spinal Cord Injuries and Disorders Systems of Care. Staffing counts are given as full-time employee equivalents: one full-time equivalent (FTE) equates to one full-time employee. For example, two 20-hour-per-week staff members are equal to, and would be reported as, one FTE.

Traumatic Brain Injury

For traumatic brain injury, services can be provided through in- or outpatient programs, and data on services are captured at the time that care is provided. Required information for the capacity reports focuses on the number of veterans served and the amount of money expended.

Blind Rehabilitation

Blind rehabilitation services can be provided at inpatient centers or through outpatient centers, and services are provided by case managers and blind rehabilitation patient specialists. Required data for the capacity report include bed and associated staffing counts, which are captured

⁸ Veterans Benefits, Health Care, and Information Technology Act of 2006, Pub. L. No. 109-461, 120 Stat. 3403 (2006); Continuing Appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017, and Zika Response and Preparedness Act, Pub. L. No. 114-223, 130 Stat. 857 (2016).

⁹ Continuing Appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017, and Zika Response and Preparedness Act.

through an administrative database at the time of service. As with spinal cord injuries and disorders, the staffing counts are in FTEs.

Prosthetics and Sensory Aids

Prosthetics and sensory aids include devices that support or replace a body part or function such as artificial limbs and bracing, wheeled mobility and seating systems, sensory-neural aids (e.g., hearing aids and eyeglasses), cognitive prosthetic devices, items specific to women's health, surgical implants and devices surgically placed in the veteran (e.g., hips and pacemakers), home respiratory care, and adaptive recreational and sports equipment. Required prosthetics and sensory aid data for the capacity reports are limited to amounts expended, and the data are collected through a program-based data system.

Mental Health

Programs for mental health are divided into five subcategories: (1) intensive community-based care, (2) opioid substitution, (3) dual diagnoses (psychiatric and substance abuse), (4) substance use disorder, and (5) general mental health. These programs can be provided at VA medical facilities, at outpatient clinics, or through inpatient programs. The capacity reports should include data on the number of programs; counts of unique veterans served; amounts expended; number of inpatient beds; and the number and type of clinics and programs, with the number of associated staff. Data are collected through an administrative database at the time of service.

For intensive community-based care programs, VA should report the number of discrete intensive care teams available to provide their services to veterans with serious mental illnesses. However, officials from VA's Northeast Program Evaluation Center told the OIG review team that they define "discrete intensive care teams" as equivalent to the count of programs for mental health intensive community-based programs. Further, although 38 U.S.C. § 1706 asks for mental health data to be reported for veterans who are "seriously mentally ill," it does not define the term, and VA does not currently use this term. Because of these limitations, the team examined the data provided in the capacity reports for programs serving all veterans with mental illnesses, not just those with serious mental illnesses.

VA Reporting Requirements Under 38 U.S.C. § 1706

VA is required to report on specific capacity measures—such as number of programs and number of beds—for each of the five special disability categories in its annual report to Congress. This information is supposed to be reported nationally, for veterans integrated service networks (VISN), and for medical facilities. The specific capacity measures included in 38 U.S.C. § 1706 are outlined in Table 1.

Table 1. 38 U.S.C. § 1706 Annual Capacity Measures

Special disability category	Annual capacity measure
1. Spinal cord injury and disorder	<ul style="list-style-type: none"> • Number of staffed beds • Number of FTEs assigned to provide care at such centers
2. Traumatic brain injury	<ul style="list-style-type: none"> • Number of veterans treated • Amounts expended
3. Blind rehabilitation	<ul style="list-style-type: none"> • Number of staffed beds • Number of FTEs assigned to provide care at such centers
4. Prosthetics and sensory aids	<ul style="list-style-type: none"> • Amounts expended
5. Mental health:	<ul style="list-style-type: none"> • Number of discrete intensive care teams available to provide such intensive services to seriously mentally ill veterans • Number of veterans treated
a) intensive community-based care	<ul style="list-style-type: none"> • Number of veterans treated • Amounts expended
b) opioid substitution programs	<ul style="list-style-type: none"> • Number of veterans treated • Amounts expended
c) dual diagnoses programs (psychiatric and substance use)	<ul style="list-style-type: none"> • Number of veterans treated • Amounts expended
d) substance use disorder programs	<ul style="list-style-type: none"> • Number of beds • Average bed occupancy • Percentage of outpatients who had two or more additional visits to specialized outpatient care within 30 days of their first visit, with a comparison to 1996 • Percentage of inpatients with substance use disorder diagnoses treated who had one or more specialized clinic visits within three days of their discharge, with a comparison to 1996 • Percentage of outpatients seen in a facility or geographic service area who had one or more specialized clinic visits, with a comparison to 1996 • Rate of recidivism of patients at each specialized clinic in each geographic service area
e) general mental health programs	<ul style="list-style-type: none"> • Number and type of staff available at each facility to provide specialized mental health treatment, including satellite clinics, outpatient programs, and community-based outpatient clinics, with a comparison to 1996 • Number of such clinics providing mental health care, and for each of these, the number and type of mental health staff and the type of mental health programs • Total amounts expended for mental health

Source: *OIG analysis of 38 U.S.C. § 1706*

Results

Issue 1: VA's Capacity Reports Contained Material Errors, Inaccuracies, Inconsistencies, and Material Changes in Capacity

The OIG identified material errors, inaccuracies, inconsistencies, and material changes in capacity from FY 2017 to FY 2018.¹⁰ Examples are provided in the section below.

Some Facility Data Differed Materially from Reports

For the requirements of 38 U.S.C. § 1706 that VA reported on, the review team identified the following material errors:

- **Spinal cord injury and dysfunction.** At a long-term care center the review team visited, the count of operational beds was 30, compared to the 34 that VA reported in its capacity reports (nearly a 12 percent difference).¹¹ Officials from VA's Spinal Cord Injuries and Disorders System of Care said they could not give a reason for the difference and did not recall any communication with the center about adjusting the bed count, even though the center provided the team documentation from the acting interim under secretary for health in November 2014 stating that VA would adjust the number of beds to 30 because this was the maximum that could fit in the space. While comparing documented data, the team also identified a material error of over 40 percent in the number of authorized beds reported for one long-term care center in the FY 2017 capacity report. Because of these findings, officials from the Spinal Cord Injuries and Disorders System of Care issued a memorandum on February 28, 2020, which directed each VISN director with at least one center in the VISN to validate the number of beds at each center by March 13, 2020, and to compare current bed counts to those reported in the directive the program office used as the reference for the number of beds in the capacity report.¹² The program office will then work to determine the causes of identified discrepancies and how to resolve them.

¹⁰ The review team defined a material change from FY 2017 to FY 2018 as an increase or decrease of equal to or greater than 10 percent and a material error as one resulting in a difference of equal to or greater than 10 percent between a reported value and an actual value (if a reported value was found to be inaccurate). The team used a 10 percent threshold to be consistent with how materiality was defined in prior OIG reviews of VA's capacity reports and based on conversations with program officials responsible for the data and the team's initial analysis of the data, to make sure this threshold was still appropriate.

¹¹ According to an official on site at the center, the review team's count of 30 operational beds that was made in May 2019 when the team visited the facility was the same operational bed count the facility had at the end of FY 2017 and FY 2018.

¹² VHA Directive 1176(2), *Spinal Cord Injuries and Disorders System of Care*, September 30, 2019 (amended February 7, 2020).

- **Mental health.** In the FY 2018 capacity report, some of the mental health appendix data and corresponding report text for the Rural Access Network for Growth Enhancement Program were materially inaccurate. While officials told the OIG that updated data were provided to VA's Office of Assistant Deputy Under Secretary for Health for Clinical Operations, the report was never updated. VA officials told the review team that the tables were inadvertently not updated before the report was published.

From FY 2017 to FY 2018, the reasons for changes in how certain mental health tables were compiled were not clearly explained. This resulted in material differences between FY 2017 numbers in the FY 2018 report and those in the actual FY 2017 report.¹³ For example, the FY 2017 Mental Health Intensive Case Management Program data in the FY 2018 report did not match the data from the FY 2017 report. Some of the difference was due to the exclusion of telephone encounters for this program in the FY 2018 data. However, part of the difference stemmed from inaccurate reporting, resulting in inaccurate data in the FY 2017 report. These errors were disclosed only when the review team asked program officials why the data differed. Further, for substance use disorder expenditures, some expenditures for one medical facility were excluded in FY 2017, resulting in a material error of 80 percent for that facility.

Capacity Reports Contained Inaccuracies and Inconsistencies

Data inaccuracies and inconsistencies also made it difficult to ascertain the accuracy of the reported information without additional information from the program offices. Furthermore, statements in the narrative were not always consistent with data provided in the accompanying tables. Examples are provided below:

- **Spinal cord injury and dysfunction.** The FY 2017 report narrative referred to "24 VA Spinal Cord Injuries and Disorders Centers," specifying that 23 provided acute care and six provided long-term care, while the report's appendix showed 24 acute centers and six long-term care centers (a difference of one acute center). Of the 30 locations in the appendix, 26 had unique names, implying that there were 26 unique centers. The review team followed up with officials from VA's Spinal Cord Injuries and Disorders System of Care and clarified that 23 centers offered acute care, five of which also offer long-term care, and one additional center offered only long-term care. Although consistent, from just the report's appendix it was unclear that two of the 24 acute locations were in one healthcare system, which resulted in 23 unique locations being referenced in the report text. It was also unclear from the appendix that one of the acute and one of the long-term

¹³ The exclusion of telephone encounters affected how FY 2017 data were reported in the FY 2018 capacity report for the Mental Health Intensive Case Management Program, the Rural Access Network for Growth Enhancement Program, the Enhanced Rural Access Network for Growth Enhancement Program, and the Psychosocial Rehabilitation and Recovery Centers.

care locations were in the same healthcare system. The OIG believes this information would also not be clear to Congress without the additional clarification the team obtained.

- **Blind rehabilitation.** The FY 2017 and FY 2018 reports included national counts for case managers and rehabilitation specialists, in addition to inpatient bed counts. However, follow-up with VA's Blind Rehabilitation Services revealed that the reported counts were for employees not directly associated with inpatient care centers or beds, as required under 38 U.S.C. § 1706. Without additional information, it would not be clear to Congress that this office did not meet the reporting requirements.
- **Mental health.** Few of the tables included clear notes explaining how variables were defined or what was included (e.g., how counts of veterans were calculated and that "discrete intensive care teams" were equivalent to the count of mental health programs). Also, the narrative and appendixes conflicted. For example, the FY 2017 report narrative indicated there were 117 mental health intensive case management programs and 108 psychosocial rehabilitation and recovery centers, while the corresponding appendixes included counts of 133 and 126 respectively. Officials from the Northeast Program Evaluation Center said the table notes explained that medical facility identification numbers were updated during FY 2017, resulting in some programs having two entries for FY 2017. However, the table note was not clear to the review team without further explanation, and the report text excluded the explanation.

VA's Office of General Counsel discovered some of these errors and inconsistencies while reviewing the FY 2017 and FY 2018 capacity reports, but VA did not incorporate the suggested changes into the reports before submitting them to Congress because no single program office was responsible for ensuring that suggested changes were incorporated into the draft. The review team attributed the discrepancies in the narrative to oversights and clerical errors, and to a lack of communication between the offices responsible for compiling the report. In addition, the OIG concluded that no one person or office in VA was responsible for ensuring the report text and appendixes for each disability area were consistent, complete, and comparable. Having one responsible person or office may reduce the number of inconsistencies and errors in VA's capacity reports.

Changes on Some Measures of Capacity from FY 2017 to FY 2018 Were Material

Changes on some of VA's measures of capacity for the five special disability areas FY 2017 to FY 2018 were material. For example, from FY 2017 to FY 2018, spinal cord injury and dysfunction centers had a material increase in staff at 13 acute and three long-term care centers, and for both acute and long-term care centers nationally. For mental health, intensive community-based care programs showed an increase in the number of veterans served of more

than 69 percent at one VA medical facility (from 91 to 154) and a decrease of 100 percent at another (from 58 to zero) from FY 2017 to FY 2018. The 100 percent change was due to the workload shifting to another program identifier in the data, which was not disclosed in the reports, but was identified during follow-up with program officials. Opioid substitution programs showed an increase in the number of veterans served of 750 percent at one VA medical facility (from eight to 68) and a decrease of 100 percent at another (from eight to zero). These changes may have been due to programs expanding, downsizing, or closing.¹⁴ Table A.1 in Appendix A summarizes the OIG team's analysis of changes in capacity from FY 2017 to FY 2018.

Issue 2: Limitations in Data Sources and Reporting Reduced the Accuracy of Capacity Reports

The team also discovered a lack of clarity and inherent data source and data reporting limitations for some of the sources used for the capacity reports. Some of the data sources that are used to compile the capacity reports have limitations that are unlikely to be addressed soon and will continue to diminish the accuracy of data reported by VA. As described below, these limitations affect information VA reported from its administrative and financial systems' data sources. VA also did not report capacity data from 1996, which affected the accuracy of the reports. Finally, the team found VA's capacity reports inaccurately depicted current capacity because they did not include all data at the national, VISN, and medical facility levels. As a result, VA's current capacity cannot be compared to capacity from 1996, data are not necessarily comparable across facilities, and data errors are difficult to identify. Table A.1 in Appendix A details VA's reporting on specific capacity measures for each special disability group and summarizes the review team's analysis of how VA's reported capacity changed from FY 2017 to FY 2018.

Limitations of Administrative Data Include Lack of Comparability and Potential for Data Errors

Administrative data are generally reported at the point of service, can be reported differently by different medical facilities, and are prone to data entry and coding errors. As a result, the data are not necessarily comparable across facilities, and data errors are difficult to identify. In addition, even though the mandate asks for patient care-related staffing data for specific programs or residential beds, staffing data provided in the capacity reports generally included nonclinical time because of limitations with how the data are currently reported in VA data systems.

Two examples follow:

¹⁴ The Northeast Program Evaluation Center provided data on the number of veterans with a possible substance use disorder and on the number of service encounters and unique veterans treated under five types of substance use disorder programs, including programs for opioid substitution treatment. The data were reviewed with the opioid treatment program data. According to officials from the Northeast Program Evaluation Center, large percentage changes in veterans served often reflect a change in a program, such as its expansion or downsizing.

- **Coding errors.** The code used to capture a specific opioid treatment program was inappropriately used by several medical facilities for other office-based types of treatment. This problem is known and is disclosed in the report, yet the officials from the Northeast Program Evaluation Center said administrative and clinical staff may still accidentally use this code for other types of services.
- **Automatic inclusion of nonclinical time.** Officials from VA's Allocation Resource Center reported VA's financial systems have limitations that impede the ability to be precise in the reporting of financial data included in the capacity reports. For example, the cost data for residential mental health programs include costs attributable to nonresidential programs, making the data imprecise for reporting on only residential costs.

The review team followed up with seven medical facilities on specific mental health data anomalies or outliers and confirmed that six of the seven had administrative or data coding errors. For example:

- One medical facility interchangeably used regular and intensive substance use disorder “stop codes” (codes that reflect the type of care given and the workload involved). This kind of coding inconsistency resulted in a material error between the FY 2017 and FY 2018 data.¹⁵
- Another facility used an incorrect code for “Intensive Substance Abuse Outpatient Group” services, resulting in a material error in its data.
- A third medical facility reported accounting issues that resulted in errors to its nursing FTE data for several months in FY 2017, resulting in what appeared to be an increase of over 700 percent in FTE nursing employees between FY 2017 and FY 2018.

Limitations of VA's Financial Systems May Impact Capacity Report Expenditure and Cost Data

The OIG's report detailing the results of an audit of VA's financial statements for FY 2017 and FY 2018 identified five material weaknesses, of which three—financial systems and reporting, information technology security controls, and entity-level controls including the chief financial officer—potentially affect the capacity reports.¹⁶ In addition, one of two significant deficiencies identified in the OIG's financial statements audit, categorized under “procurement, undelivered orders, accrued expenses, and reconciliations,” may impact the capacity reports. A significant

¹⁵ Stop codes reflect the type of outpatient care provided and record the workload in mental health programs. For example, telephone encounters are captured under a telephone stop code.

¹⁶ VA Office of Inspector General, *Audit of VA's Financial Statements for Fiscal Years 2018 and 2017*, 18-01642-09, November 26, 2018.

deficiency is a deficiency or combination of deficiencies that is less severe than a material weakness but important enough to merit attention by those charged with governance. While these weaknesses and deficiencies are specific to the OIG's review of VA's financial statements, they may affect the reliability of expenditure and cost data included in the capacity reports. In addition, the weaknesses in information technology security control and entity-level controls may diminish the reliability of systems supporting the capacity report because the financial data in these reports are extracted from the same financial systems.

Changes in How Data Systems Capture Information on Specific Disabilities Limited VA's Ability to Compare to Its 1996 Capacity

Officials from all five offices told the OIG review team that it would be difficult or impossible to compare VA's capacity in FY 2017 and FY 2018 to its 1996 capacity. Even if VA could accurately report on its 1996 capacity, doing so would provide limited value to Congress for the following reasons:

- There have been fundamental changes in how disabilities are diagnosed and how medical conditions are treated, including changes to the clinical definitions and needs of these groups. For example, while VA must report the required data points for veterans with "serious mental illness," the VA Office of Mental Health and Suicide Prevention does not currently use the term "seriously mentally ill" due to a lack of a commonly accepted and agreed-upon definition.
- There have been changes in how care is provided for the five special disability groups. For example, the decrease in the provision of inpatient mental health care, increase of care in outpatient settings, and implementation of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 affect how and where veterans seek care, including how many seek care outside VA.¹⁷ In addition, data on medical care provided by private providers outside VA are not easily available and cannot be included in reports assessing VA's capacity to provide care to veterans.
- There have been significant changes in the data systems used by VA and in data coding (e.g., changes in the classification system for patients with traumatic brain injury). These changes make comparisons with 1996 data difficult or impossible.

Finally, although VA is also required to report on the recidivism rate for patients treated at specialized mental health clinics, officials from the Northeast Program Evaluation Center told the review team that VA no longer collects data on recidivism for mental health programs

¹⁷ John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018).

because it is not an appropriate outcome measure for this population. The OIG believes that VA is no longer able to fully meet the requirement to compare to its 1996 capacity because of changes to medical diagnoses, treatments, treatment settings, infrastructure, information technology, data systems, and terminology since 1996. The OIG also believes that Congress is better positioned to assess VA's current capacity to provide care for today's veterans disabled by spinal cord injuries, traumatic brain injuries, blindness, or mental illness, or with the need for prosthetics and sensory aids by requiring VA, for example, to report on its capacity from one year to the next and by considering the extent to which VA can meet the demand veterans affected by these disabilities have for its care and services.

Some Data Were Not Reported at National, Veterans Integrated Service Network, and Medical Facility Levels

The accuracy of the capacity reports was further affected because VA did not consistently report data at the national, VISN, and medical facility levels, as described below.

- **Traumatic brain injury.** VA reported on amounts expended in FY 2018, but only at the national level.
- **Blind rehabilitation.** VA reported on the number of staffed beds for FY 2017 and FY 2018, but only nationally. VA did not report on staff assigned to provide care associated with beds for FY 2017 or FY 2018.
- **Prosthetics and sensory aids.** VA reported amounts expended for FY 2018 but not for FY 2017, making it impossible to compare FY 2017 with FY 2018.
- **Mental health dual diagnoses programs** (psychiatric and substance use). VA reported on amounts expended in FY 2018, but only nationally.
- **Mental health substance use disorder programs.** Although VA fully reported on the number of beds and the average bed occupancy rate in FY 2017 and FY 2018, VA did not report on the other four substance use disorder requirements shown in Table 1 of this report (see also Table A.1, section d).
- **Mental health programs.** VA did not report at the clinic level on staff number and type, or on the number and type of selected mental health programs for FY 2017 and FY 2018.

Table A.1 in Appendix A provides further details.

Conclusion

With the exception of the effects of the material errors, inaccuracies, inconsistencies, material changes from FY 2017 to FY 2018, and data limitations discussed in the results section of this report, nothing came to the review team's attention that caused the OIG to believe that the

information required by 38 U.S.C. § 1706 in the FY 2017 and FY 2018 capacity reports is not fairly stated and accurate in all material respects. That conclusion is based on attestation standards used for this review. VA cannot accurately report its 1996 capacity because of data source limitations and changes in medical diagnoses, treatments, treatment settings, infrastructure, information technology, data systems, and terminology. However, the OIG believes that even if VA could do so, it would not provide Congress with assurances that VA's current capacity is adequate to meet the needs of today's veterans disabled by spinal cord injuries, traumatic brain injuries, blindness, or mental illness, or with the need for prosthetics and sensory aids.

Management Comments

The executive in charge, Office of the Under Secretary for Health, concurred with the contents of the draft report and provided the OIG with general and technical comments. VHA also provided the OIG with representation letters for both FY 2017 and FY 2018, as required by attestation review standards.

OIG Response

After reviewing the VA comments, the OIG incorporated references in the report conclusion to the fact that changes in treatment settings, infrastructure, and information technology, in addition to other limitations already discussed by the OIG, affected VA's ability to compare its current capacity to 1996. The OIG included information about a memorandum issued by the Spinal Cord Injuries and Disorders System of Care program office directing VISN directors to validate the number of beds at centers in their VISNs to address the OIG's report findings. The OIG also updated the report language related to a lack of clarity around the number of centers reported on in the capacity reports as compared to the related report appendixes to reference the 24 acute and six long-term care centers described in the text of the FY 2017 and FY 2018 capacity reports.

Appendix A: Analysis of VA's Reporting on Special Disability Groups and Changes in Capacity from FY 2017 to FY 2018

Table A.1 details VA's reporting on special disability groups by category and summarizes the review team's analysis of how VA's reported capacity changed from FY 2017 to FY 2018.¹⁸

Table A.1. Capacity Measures and Analysis of Material Changes in VA's Capacity from FY 2017 to FY 2018

Capacity Measure ¹	Did VA report data on this capacity measure in FY 2017?	Did VA report data on this capacity measure in FY 2018?	Material changes in VA's capacity from FY 2017 to FY 2018
<i>Spinal cord injury and dysfunction specialized centers—Spinal Cord Injuries and Disorders System of Care</i>			
Number of staffed beds	Yes	Yes	Material changes: Increases in operational beds at one acute and one long-term care center and a decrease at one acute center. Increase in authorized beds at one long-term care center and nationally. ²
Number of full-time equivalent employees assigned to provide care at such centers ³	Yes	Yes	Material changes: Increases in full-time equivalent employees at 13 acute and three long-term care centers and for acute and long-term care centers nationally.
<i>Traumatic brain injury—Polytrauma/Traumatic Brain Injury System of Care</i>			
Number of veterans treated	Yes	Yes	Material changes: Increase in number of veterans treated nationally and at 56 medical facilities. Decrease in number treated at four facilities.
Amounts expended	No	Partial: amount provided only nationally and not by VISN or medical facility	Not applicable

¹⁸ The OIG calculated material changes in VA's capacity from FY 2017 to FY 2018 using data provided in the capacity report appendixes.

Capacity Measure ¹	Did VA report data on this capacity measure in FY 2017?	Did VA report data on this capacity measure in FY 2018?	Material changes in VA's capacity from FY 2017 to FY 2018
Blind rehabilitation specialized centers—Blind Rehabilitation Services			
Number of staffed beds	Partial: bed count provided only nationally and not by VISN or medical facility	Partial: bed count provided only nationally and not by VISN or medical facility	No material changes.
Number of full-time equivalent employees assigned to provide care at such centers ³	No	No	Not applicable
Prosthetics and sensory aids—Prosthetic and Sensory Aid Services			
Amounts expended	No	Yes	Not applicable
Mental health			
a) Mental health intensive community-based care—Northeast Program Evaluation Center			
Number of discrete intensive care teams available to provide such intensive services to seriously mentally ill veterans	Yes	Yes	No material changes. ⁴
Number of veterans treated	Yes	Yes	Material changes in number of veterans served at multiple medical facilities. One facility had more than a 69 percent increase and another a 100 percent decrease. ⁵
b) Opioid substitution programs—Northeast Program Evaluation Center			
Number of veterans treated	Yes	Yes	Material changes in number of veterans served at multiple medical facilities. One facility had a 750 percent increase, and another had a 100 percent decrease. ⁶
Amounts expended	Yes	Yes	Material changes at multiple medical facilities. One facility had an increase of more than 1,187 percent and another a 100 percent decrease.

Capacity Measure ¹	Did VA report data on this capacity measure in FY 2017?	Did VA report data on this capacity measure in FY 2018?	Material changes in VA's capacity from FY 2017 to FY 2018
c) Patients with dual diagnoses (psychiatric and substance use)—Northeast Program Evaluation Center			
Number of veterans treated	Yes	Yes	Material changes in number of veterans served at multiple medical facilities. One facility had an increase of over 22 percent, and one had a decrease of about 15 percent.
Amounts expended	No	Partial: amount provided only nationally and not by VISN or medical facility	Not applicable
d) Substance use disorder programs—Northeast Program Evaluation Center			
Number of beds employed	Yes	Yes	Material changes in number of beds at some medical facilities. One facility had an increase of over 82 percent, and one had a decrease of about 27 percent.
Average bed occupancy of such beds	Yes	Yes	Material changes in average daily occupancy rates at some medical facilities. One facility had an increase of over 217 percent and another a decrease of about 83 percent.
Percentage of outpatients who had two or more additional visits to specialized outpatient care within 30 days of their first visit, with a comparison to 1996	No	No	Not applicable
Percentage of inpatients with substance use disorder diagnoses treated who had one or more specialized clinic visits within three days of their index discharge, with a comparison to 1996	No	No	Not applicable
Percentage of outpatients seen in a facility or geographic service area who had one or more specialized clinic visits, with a comparison to 1996	No	No	Not applicable

Capacity Measure ¹	Did VA report data on this capacity measure in FY 2017?	Did VA report data on this capacity measure in FY 2018?	Material changes in VA's capacity from FY 2017 to FY 2018
Rate of recidivism of patients at each specialized clinic in each geographic service area	No	No	Not applicable
e) Mental health programs—Northeast Program Evaluation Center			
Number and type of staff available at each facility to provide specialized mental health treatment, including satellite clinics, outpatient programs, and community-based outpatient clinics, with a comparison to 1996 ³	Partial: full-time equivalent employee staff numbers provided only by medical facility, VISN, and nationally, not by clinic	Partial: full-time equivalent employee staff numbers provided only by medical facility, VISN, and nationally, not by clinic	Material changes for full-time equivalent employees at multiple medical facilities. One facility had an increase of over 1,181 percent and another a decrease of about 45 percent.
Number of such clinics providing mental health care, and for each of these the number and type of mental health staff and the type of mental health programs	Partial: program count provided only by medical facility, VISN, and nationally, and not by clinic	Partial: program count provided only by medical facility, VISN, and nationally, and not by clinic	Material changes for number of programs at some medical facilities: one facility had an increase of 100 percent; another had a decrease of 50 percent.
Total amounts expended	Yes	Yes	Material changes at multiple medical facilities: one facility had an increase of over 54 percent and another a decrease of about 32 percent.

Source: OIG analysis of VA's FY 2017 and FY 2018 Special Disabilities Capacity reports

¹ 38 U.S.C. § 1706.

² The review team defined a material change from FY 2017 to FY 2018 as an increase or decrease of equal to or greater than 10 percent. The material differences for long-term care may be due to a reporting error.

³ The "number of staff" are reported as FTEs. Staff data may include nonclinical time because of administrative data limitations and may not accurately depict staff time spent on only clinical care.

⁴ VA officials told the review team that they define "discrete intensive care teams" as equivalent to the count of programs for each of four mental health intensive community-based programs.

⁵ The large number of increases and decreases occurred, at least in part, because of a change in how one outpatient stop code was used and a coding error.

⁶ The review team analyzed data provided for opioid substitution treatment programs in addition to data provided for four other types of substance abuse treatment programs. The capacity reports disclose that several medical facilities inappropriately used the opioid substitution program code for other office-based treatments, and officials from the Northeast Program Evaluation Center said that some of these programs did not have official opioid treatment programs. However, the review team based its FY 2017 to FY 2018 comparative analyses on the data published in the reports.

Appendix B: Scope and Methodology

Scope

The review team conducted its work from March 2019 to February 27, 2020. The team sought to assess if VA's FY 2017 and FY 2018 Special Disabilities Capacity Reports accurately reflected VA's in-house capacity to provide for the specialized treatment and rehabilitative needs of specified categories of disabled veterans, as required by Title 38, United States Code, Section 1706 (38 U.S.C. § 1706).

Methodology

The review team interviewed staff from the program offices that contributed data to the FY 2017 and FY 2018 capacity reports to gain an understanding of the data systems and types of data VA used to generate the capacity reports.

The review team first reviewed the capacity reports against the criteria in 38 U.S.C. § 1706 to identify the components of the reports that addressed the requirements. Based on this analysis, the team determined that 26 of 55 data tables for FY 2017 and 28 of 57 data tables for FY 2018 met mandate requirements. Data tables that did not address requirements were not included in the review.

The review team conducted the following analytic procedures to assess the accuracy of the information VA reported in its FY 2017 and FY 2018 capacity reports:

- Identified capacity measures that VA did not report on, to determine if missing data elements materially affected the accuracy of the capacity reports.
- Compared data from the tables to related text from the capacity reports to identify any inconsistencies.
- Replicated a sample of key data tables to verify the accuracy of the reported data.
- Performed site inspections of two Spinal Cord Injury and Disorder Centers—West Roxbury and Brockton, MA—to physically verify VA's bed and staffing data contained in the capacity reports. Site visits were performed for this disability area because the data related to this area are unique and do not originate from a VA data system, but instead come from a monthly survey administered by the Spinal Cord Injuries and Disorders System of Care program office, and the team could not replicate the data to verify its accuracy.
- Analyzed the data tables to identify mathematical or other errors and performed a year-over-year analysis of the data to identify any material changes—increases or decreases equal to or greater than 10 percent, or anomalies (e.g., significant decreases)—and used

professional judgment to select some medical facilities to follow up with about material changes or anomalies.

- Assessed the results of VA's FY 2017 and FY 2018 financial audit and determined which findings might affect the data or data systems used for the capacity reports.
- Assessed if VA coordinated with the Advisory Committee on Prosthetics and Special Disabilities Programs and the Committee on Care of Severely Chronically Mentally Ill Veterans for the capacity reports.
- Interviewed representatives from two veterans service organizations to obtain their insights on the capacity reports.

Internal Controls

Internal controls related to communication were significant to this attestation review. To assess these controls, the review team conducted interviews with officials from the following VA offices—Spinal Cord Injuries and Disorders System of Care; Polytrauma/Traumatic Brain Injury System of Care; Blind Rehabilitation Services; Prosthetic and Sensory Aid Service; and the Northeast Program Evaluation Center—and from VA's Office of Congressional and Legislative Affairs, Office of the Deputy Under Secretary for Health for Policy and Services, and Office of the Assistant Deputy Under Secretary for Health for Clinical Operations. The team also reviewed internal communication between VA offices to identify the level and type of guidance provided to the program offices specific to the reporting requirements.

Fraud Assessment

The review team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur within the context of the review objective, and took the following actions:

- Coordinated this review with the OIG's Office of Investigations.
- Asked about the risk of fraud, waste, or abuse during interviews with program offices.
- Considered potential fraud indicators when reviewing data tables, such as looking at large fluctuations or outliers, and followed up with VA on identified anomalies.

The OIG did not identify any instances of fraud or potential fraud specific to the capacity reports.

Data Reliability

This attestation review was designed to provide a moderate level of assurance as to whether the subject matter is presented accurately and fairly, to present a conclusion, and to accumulate sufficient evidence to restrict attestation risk to a moderate level, as required by the American Institute of Certified Public Accountants review attestation standards. The procedures the review

team performed were generally limited to inquiries and analytical procedures to assess the accuracy of the data VA reported in its capacity reports. The review team determined that the data in VA's capacity reports was sufficiently reliable for our purpose of reviewing the accuracy of VA's reported data. To do so, the team compared data from the report text to the appendix tables to identify inconsistencies, analyzed data tables to identify mathematical errors, performed a year-over-year analysis of the data to identify any increases or decreases equal to or more than 10 percent or anomalies, and followed up with program office officials and some medical facilities. In addition, OIG replicated a sample of key data tables to see if the results would be similar to those provided by VA when the same parameters were applied. For the one disability area for which the data could not be replicated, the team performed two site visits to count the number of beds and compare the team's physical counts to what VA reported. Finally, the team interviewed representatives from the program offices that are responsible for compiling the capacity report to ask if they were aware of any limitations with the sources that could impact the accuracy of the data in the capacity reports. The team did not test the reliability of the information systems used to compile the data in the capacity reports because it was beyond the scope of this attestation review.

Government Standards

The OIG conducted this review in accordance with attestation standards established by the American Institute of Certified Public Accountants and by the applicable generally accepted government auditing standards. An attestation review is substantially less in scope than an examination. The objective of an examination is the expression of an opinion on the assertions in the submission. The OIG does not express such an opinion.

Appendix C: Management Comments

Department of Veterans Affairs Memorandum

Date: March 13, 2020

From: Executive In Charge, Office of the Under Secretary for Health (10)

Subj: OIG Draft Report, Department of Veterans Affairs: Independent Review of VA's Fiscal Years 2017 and 2018 Special Disabilities Capacity Reports (Project Number: 2019-06382-R1-0003) (VIEWS 02508124)

To: Assistant Inspector General for Audit and Evaluations (52)

Thank you for the opportunity to review the Office of Inspector General's (OIG), Department of veterans Affairs: Independent Review of VA's Fiscal Years 2017 and 2018 Special Disabilities Capacity Reports.

I concur with the content of the draft report and provide the attached attestation memos for consideration. I also provide general and technical comments for your consideration.

If you have any questions, please email Karen Rasmussen, M.D., Director, GAO-OIG Accountability Liaison Office at VHA10EGGOALACTION@va.gov.

(Original Signed By)

Richard A. Stone, M.D.

Attachments

VHA General Comments

OIG Draft Report – Independent Review of VA's Fiscal Years 2017 and 2018 Special Disabilities Capacity Report

Comment 1

Draft location:

Section named, "Conclusion" (first paragraph, page iv.)

Section named, "Changes in How Data Systems Capture Information on Specific Disabilities Limited VA's Ability to Compare to its 1996 Capacity" (second paragraph, page 10)

Section named, "Conclusion" (first paragraph, page 11)

Current language (used in the above referenced sections of the document):

Language used in reference 1:

"The OIG believes that VA is no longer able to fully meet the requirement to compare to 1996 capacity because of changes to medical diagnoses, treatments, data systems, and terminology since 1996."

Language used in reference 2:

"The OIG believes that VA is no longer able to fully meet the requirement to compare to its 1996 capacity because of changes to medical diagnoses, treatments, data systems, and terminology since 1996."

Language used in reference 3:

"VA cannot accurately report its 1996 capacity because of changes to medical diagnoses, treatments, data systems, and terminology since 1996."

Comment and justification:

Suggest revision of the current language to all of the above referenced sections of the document to reflect additional factors that prevent VA from being able to fully meet the requirement to compare to its 1996 capacity:

"The OIG believes that VA is no longer able to fully meet the requirement to compare to its 1996 capacity because of changes to medical diagnoses, treatments, treatment settings, infrastructure, information technology, data systems, and terminology since 1996."

Suggest adding "treatment settings" to reflect the changes in care settings throughout VA and the American health care system from the inpatient to outpatient settings, as well as to telehealth, home care, and self-management

Suggest adding "infrastructure" to reflect changes in locations and/or inpatient bed capacity that vary over time (e.g. the number of SCI/D Centers and beds has increased since 1996)

Suggest adding "information technology" to reflect the increasing availability and use of telehealth and other information technology that supports medical and health care throughout VA and the American health care system

VHA Technical Comments

OIG Draft Report – Independent Review of VA's Fiscal Years 2017 and 2018 Special Disabilities Capacity Report

Comment 1

Draft location:

Section named, "Some Facility Data Differed Materially from Reports" (first sub-paragraph, page 5).

Current language:

"Because of these findings, officials from the Spinal Cord Injuries and Disorders System of Care told the review team that they plan to draft a memorandum directing VISN directors with at least one center to validate the number of beds at each center."

Comment and justification:

Request revision of the current language to the following to reflect the most current information related to the plan to address SCI/D System of Care bed counts:

"Because of these findings, the VA Spinal Cord Injuries and Disorders (SCI/D) System of Care National Program Office drafted a memorandum for signature by the Deputy Under Secretary for Health for Operations and Management (DUSHOM) directing leaders of the Veterans Integrated Service Networks (VISN) that have at least one SCI/D Center in their VISN's catchment area to validate the number of authorized and operating acute/sustaining and/or long term care beds in their respective SCI/D Center(s). A primary intent of this review is to compare the current bed counts to those reported in [VHA Directive 1176\(2\), Spinal Cord Injuries and Disorders System of Care](#), dated September 30, 2019, and amended February 7, 2020, which is used as the reference for the number of beds reported in the Capacity Report. This memorandum received concurrence from the Assistant Deputy Under Secretary for Health for Clinical Operations, was signed on behalf of the DUSHOM on February 28, 2020, and was dispatched to VISN Directors on March 2, 2020."

Comment 2

Draft location:

Section named, "Capacity Reports Contained Inaccuracies and Inconsistencies" (first sub-paragraph, page 6).

Current language:

"The FY 2017 report narrative referred to '24 VA Spinal Cord Injuries and Disorders Centers,' while the appendix showed 24 acute centers and six long-term care centers. The review team followed up with officials from VA's Spinal Cord Injuries and Disorders System of Care and clarified that 23 centers offered acute care, five of which also offer long-term care, and one additional center offers only long-term care. However, this would not be clear to Congress without the clarification the team obtained."

Comment and justification:

For the reports for both fiscal years, due to space constraints and the volume of data, the break-out of bed types for the 24 SCI/D Centers was provided in the narrative, which specified that 23 of the 24 SCI/D

Centers have acute/sustaining beds and six of the 24 have actively utilized long-term care beds. The specific language used in the reports is provided below:

The Capacity Report CMR for FY 2017 submitted to Congress, dated November 2018: The content on page 13 under the heading "Spinal Cord Injuries and Disorders {1706(b)(3)(A)}" states, "There are 24 VA Spinal Cord Injuries and Disorders (SCI/D) Centers, which provide lifelong primary and specialty care for Veterans with SCI/D in inpatient, outpatient, and home care settings, dedicated inpatient beds for acute/sustaining care, and/or long-term care. Twenty-three of the 24 SCI/D Centers have acute/sustaining beds, and six of the 24 have actively utilized long-term care beds."

The Capacity Report CMR for FY 2018 submitted to Congress, dated March 2019: The content on page 14 under the heading "Spinal Cord Injuries and Disorders" states, "There are 24 VA SCI/D Centers, which provide lifelong primary and specialty care for Veterans with SCI/D in inpatient, outpatient, and home care settings, dedicated inpatient beds for acute/sustaining care and/or long-term care. Twenty-three of the 24 SCI/D Centers have acute/sustaining beds and six of the 24 have actively utilized long-term care beds."

For the FY 2019 Capacity Report CMR, the SCI/D System of Care National Program Office will re-evaluate the current data reporting format and consider revisions as appropriate to assist with readability and clarity.

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

Appendix D: Management Representation Letters

Department of Veterans Affairs Memorandum

Date: February 27, 2020

From: Executive in Charge, Office of the Under Secretary (10)

Subj: Management Memorandum for Department of Veterans: Independent Review of the VA's Fiscal Years (FY) 2017 Special Disabilities Capacity Reports (Project Number: 2019-06382-R1-0003)

To: Assistant Inspector General for Audit and Evaluations (52)

We are providing this memorandum in connection with the Office of the Inspector General's (OIG) independent attestation review of the Department of Veterans (VA)'s fiscal year (FY) 2017 Special Disabilities Capacity Report. This review was to assess VA's reporting of its capacity for FY 2017 to provide for the specialized treatment and rehabilitation of specified categories of disabled Veterans.

VA is responsible for the fair presentation of all statements in the FY 2017 Special Disabilities Capacity Report in conformity with Title 38, United States Code, Section 1706 (38 U.S.C. § 1706). This statute requires VA to maintain its in-house capacity to provide for the specialized treatment and rehabilitative need of disabled Veterans with mental illness, spinal cord dysfunction, traumatic brain injury, blindness, or prosthetics and sensory aides. VA believes the statements, and other information in the subject report, are fairly presented in conformity with the law, unless otherwise disclosed in the report.

VA is responsible for the data definitions used in the FY 2017 Special Disabilities Capacity Report, and VA believes those definitions are appropriate and consistent with the requirements of 38 U.S.C. § 1706, unless otherwise disclosed in the report.

VA made available to the OIG the following:

The FY 2017 Special Disabilities Capacity Report required by 38 U.S.C. § 1706;

All supporting records, related information, and program and financial data relevant to the special disability programs included in the FY 2017 Special Disabilities Capacity Report;

Communications, if any, from oversight bodies concerning the FY 2017 Special Disabilities Capacity Report; and

Access to VA officials responsible for overseeing the programs that provided services to Veterans with mental illness, spinal cord dysfunction, traumatic brain injury, blindness, or prosthetics and sensory aides.

VA confirms the FY 2017 Special Disabilities Capacity Report was prepared in accordance with 38 U.S.C. § 1706. VA has no knowledge of instances in which VA did not report required information under 38 U.S.C. § 1706 in the FY 2017 Special Disabilities Capacity Report, except for those instances disclosed in the report.

VA is not aware of any events that have occurred subsequent to September 30, 2017, that would influence the FY 2017 Special Disabilities Capacity Report and the information therein. There have been no material changes in the FY 2017 Special Disabilities Capacity Report since the report was submitted to the Congress on November 21, 2017.

VA believes the effects of any uncorrected misstatements in the FY 2017 Special Disabilities Capacity Report are immaterial, both individually and in aggregate, to the report taken as a whole.

VA is responsible for the design and implementation of program processes and internal controls to prevent and detect fraud. VA has no knowledge of deficiencies in internal controls or of fraud, or suspected fraud, that could have a material effect on the FY 2017 Special Disabilities Capacity Report.

VA understands the OIG review was conducted in accordance with the attestation standards established by the American Institute of Certified Public Accountants, and the applicable standards contained in Government Auditing Standards, issued by the Comptroller General of the United States. An attestation review is substantially less in scope than an examination and accordingly, you will not express an opinion on the FY2017 Special Disabilities Capacity Report.

Certain representations in this memo are described as being limited to matters that are material. VA considers items to be material, regardless of size, if they involve an omission or misstatement of information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

Requirements for this report were mandated in 1996 and some of those requirements are incongruent with the Department's delivery of health care today. Advancements in medical practice, delivery of treatment and rehabilitation, and changes in the collection and management of data (outcomes, metrics, etc.) may account for inaccuracies, inconsistencies and material changes in capacity for FY 2017 compared to 1996.

I confirm, to the best of our knowledge and belief, the representations made to OIG during this attestation review are accurate and pertain to FY 2017, which ended September 30, 2017.

(Original Signed By)

Richard A. Stone, M.D.

Attachment

Department of Veterans Affairs Memorandum

Date: February 27, 2020

From: Executive in Charge, Office of the Under Secretary (10)

Subj: Management Memorandum for the Department of Veterans Affairs: Independent Review of VA's Fiscal Year (FY) 2018 Special Disabilities Capacity Report (Project Number:2019-06382-R1-0003) (VIEWS 02508124)

To: Assistant Inspector General for Audit and Evaluations (52)

We are providing this memorandum in connection with the Office of the Inspector General's (OIG) independent attestation review of the Department of Veterans Affairs (VA)'s fiscal year (FY) 2018 Special Disabilities Capacity Report. This review was to assess VA's reporting of its capacity for FY 2018 to provide for the specialized treatment and rehabilitation of specified categories of disabled Veterans.

VA is responsible for the fair presentation of all statements in the FY 2018 Special Disabilities Capacity Report in conformity with Title 38, United States Code, Section 1706 (38 U.S.C. § 1706). This statute requires VA to maintain its in-house capacity to provide for the specialized treatment and rehabilitative need of disabled Veterans with mental illness, spinal cord dysfunction, traumatic brain injury, blindness, or prosthetics and sensory aides. VA believes the statements, and other information in the subject report, are fairly presented in conformity with the law, unless otherwise disclosed in the report.

VA is responsible for the data definitions used in the FY 2018 Special Disabilities Capacity Report, and VA believes those definitions are appropriate and consistent with the requirements of 38 U.S.C. § 1706, unless otherwise disclosed in the report.

VA made available to the OIG the following:

The FY 2018 Special Disabilities Capacity Report required by 38 U.S.C. § 1706;

All supporting records, related information, and program and financial data relevant to the special disability programs included in the FY 2018 Special Disabilities Capacity Report;

Communications, if any, from oversight bodies concerning the FY 2018 Special Disabilities Capacity Report; and

Access to VA officials responsible for overseeing the programs that provided services to Veterans with mental illness, spinal cord dysfunction, traumatic brain injury, blindness, or prosthetics and sensory aides.

VA confirms the FY 2018 Special Disabilities Capacity Report was prepared in accordance with 38 U.S.C. § 1706. VA has no knowledge of instances in which VA did not report required information under 38 U.S.C. § 1706 in the FY 2018 Special Disabilities Capacity Report, except for those instances disclosed in the report.

VA is not aware of any events that have occurred subsequent to September 30, 2018, that would influence the FY 2018 Special Disabilities Capacity Report and the information therein. There have been no material changes in the FY 2018 Special Disabilities Capacity Report since the report was submitted to the Congress on November 21, 2018.

VA believes the effects of any uncorrected misstatements in the FY 2018 Special Disabilities Capacity Report are immaterial, both individually and in aggregate, to the report taken as a whole.

VA is responsible for the design and implementation of program processes and internal controls to prevent and detect fraud. VA has no knowledge of deficiencies in internal controls or of fraud, or suspected fraud, that could have a material effect on the FY 2018 Special Disabilities Capacity Report.

VA understands the OIG review was conducted in accordance with the attestation standards established by the American Institute of Certified Public Accountants, and the applicable standards contained in Government Auditing Standards, issued by the Comptroller General of the United States. An attestation review is substantially less in scope than an examination and accordingly, you will not express an opinion on the FY 2018 Special Disabilities Capacity Report.

Certain representations in this memorandum are described as being limited to matters that are material. VA considers items to be material, regardless of size, if they involve an omission or misstatement of information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

Requirements for this report were mandated in 1996 and some of those requirements are incongruent with the Department's delivery of health care today. Advancements in medical practice, delivery of treatment and rehabilitation, and changes in the collection and management of data (outcomes, metrics, etc.) may account for inaccuracies, inconsistencies and material changes in capacity for FY 2018 compared to 1996.

I confirm, to the best of our knowledge and belief, the representations made to OIG during this attestation review are accurate and pertain to FY 2018, which ended September 30, 2018.

(Original Signed By)

Richard A. Stone, M.D.

<p><i>For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.</i></p>

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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